EYES
ON STONEHAVEN

Welcome to our office. We strive for excellence in vision and will do our best to provide you with the best possible care. Please fill out this form and return it to the front desk.

Mr./Ms./Mrs./Miss. (circle)		Last Name		First Name	
Age	Gender	Date of Birth (dd/mm/yyyy)		Health Card #	Version Code
	M/F				
Address					Apt/Suite
City		Postal Code		E-Mail	
Home Phone #		Work Phone #		Cell Phone #	

What is the reason for your visit today? ____

When was your last eye exam? ______________________ With whom? ___________________________

What is your occupation? __________________ How many hours per day do you use a computer?_________

Do you wear contact lenses? Yes ☐ No ☐ Would you like information on laser vision correction? Yes ☐ No ☐

How did you hear about our office? Family doctor ☐ Internet ☐ Friend/family ☐ Street sign ☐

Ocular History

Have **you** or your **family members** ever been diagnosed with the following? Please specify which person is/was affected.

Lazy eye (ambylopia) No ☐ Yes ☐ Who____________
Crossed eye (strabismus) No ☐ Yes ☐ Who____________
Glaucoma No ☐ Yes ☐ Who____________
Cataracts No ☐ Yes ☐ Who____________
Macular degeneration No ☐ Yes ☐ Who____________

Have you ever had an injury/surgery to the eye? No ☐ Yes ☐ if yes please explain:______________________

Medical History

Have **you** or your **family members** ever been diagnosed with the following? Please specify which person is/was affected.

High blood pressure No ☐ Yes ☐ Who____________
Diabetes No ☐ Yes ☐ Who____________
Heart disease No ☐ Yes ☐ Who____________
Cancer No ☐ Yes ☐ Who____________
High cholesterol No ☐ Yes ☐ Who____________

Do you take any medications? No ☐ Yes ☐
if yes please list: _________________________

Who is your family doctor? ______________________________ Phone #_________________________